MEMORANDUM OF UNDERSTANDING (PROVIDER ENROLLMENT AGREEMENT)

TO RECEIVE VACCINE FROM THE IDAHO IMMUNIZATION PROGRAM AND THE VACCINES FOR CHILDREN PROGRAM

January 1, 2004

Medical/Agency Director						
(authorized to sign for practice/agency)	Last		First		MI	
Clinic/Practice/Agency:						
Mailing Address:						
Street		City		State	Zip	

To participate in the Idaho Vaccine Program which includes the federal Vaccines for Children (VFC) program and to receive federal and state procured vaccine at no cost, I, on behalf of myself and all practitioners for whom I am the medical/agency director or equivalent, agree to the following:

- 1. Before administering vaccine provided through the Idaho Vaccine Program, I will screen <u>all</u> patients 0-18 years of age to determine eligibility for the VFC program. (We recommend use of the Idaho Patient Eligibility Screening Form or the Vaccine Administration Card to complete this screening requirement.)
- 2. I will retain the parent/guardian responses about VFC eligibility status of a period of three years. If requested, these records and patient immunization records will be made available to the Idaho Immunization Program and/or the U.S. Department of Health and Human Services (DHHS).
- 3. I will permit visits to my facility by authorized representatives of the Idaho Immunization Program or Federal Department of Health & Human Services to review compliance with VFC Program requirements, to include patient chart review, vaccine handling & storage, administration techniques, and other applicable immunization subjects. Release of such records will be bound by the privacy protection of the federal Medicaid law and falls within the HIPAA Privacy Rules 45 CFR § 164.512(b)
- 4. Administer vaccines in accordance with the current immunization recommendations, the FDA licensing requirements, and policies established by the Idaho Immunization Program and the Advisory Committee on Immunization Practices (ACIP), unless, (a) in making a medical judgment in accordance with accepted medical practice, a practitioner deems such compliance to be medically inappropriate or (b) the particular requirement is not in compliance with the law of Idaho including state laws relating to religious or other exemptions.
- 5. Assure that parent(s) or guardian(s) will receive the appropriate Vaccine Information Statement(s) prior to the administration of any vaccine and that immunization records will be maintained in

accordance with the National Childhood Vaccine Injury Act (see Vaccine Program Policies and Guidelines, page 2). Vaccine adverse events listed in the Vaccine Injury Table (National Childhood Vaccine Injury Act) reported to me will be forwarded in accordance with the VAERS protocol.

- 6. A charge for the cost of the vaccine will not be imposed.
- 7. The maximum vaccine administration fee charged will not exceed fourteen dollars and 34 cents (\$14.34) per shot. (A combination vaccine administered through a single syringe is considered one shot)
- 8. No child will be denied the administration of any vaccine received from the Idaho Immunization Program due to the inability of the child's parent or guardian to pay the vaccine administration fee.
- 9. Assure compliance with the procedures outlined by the Idaho Immunization Program for ordering, storing and handling vaccines.
- 10. Assure that the "Provider Profile" report, required by the VFC program, will be completed and submitted with the Memorandum of Understanding (MOU)/Enrollment Agreement.
- 11. Assure that accurate monthly vaccine accountability reports (which includes a monthly inventory on hand report) will be forwarded to the Idaho Immunization Program by the 15th day of the following month in accordance with the procedures outlined by the Idaho Immunization Program.
- 12. Assure that vaccine received from the Idaho Immunization Program will not be distributed to <u>any</u> other health care provider without <u>prior</u> authorization from the Idaho Immunization Program.
- 13. To return all unusable vaccine(s) to the Idaho Immunization Program.
- 14. To purchase and install, within six months of such a request, a temperature sensitive 24 hour alarm system with after hours notification, for any single site which contain vaccines, at any single point in time, valued at or above \$15,000. I understand that the Idaho Immunization Program will notify me in writing if this requirement applies to us.
- 15. To install in all refrigerators and freezers which store vaccines, a thermometer(s) that will provide both the minimum and maximum temperatures of each unit.
- 16. I shall reimburse the Idaho Immunization Program for the value of vaccine that has been wasted due to negligence. Negligence may be considered, but not limited to: inadequate or improper handling, not maintaining the vaccine according to the standards described in the poster titled, "Recommendations for Handling and Storage of Vaccines." (A copy of this poster was mailed to each provider in 2001, copies are available upon request)
- 17. I or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

I certify that I have read and agree to the re Idaho State Vaccine and the federal Vaccine	quirements listed above pertaining to participation in the es for Children Program.
Provider Signature (person authorized to sign for practice/clinic/corporation.)	Date
Employer Identification #:	
For Medical Directors and solo practitioners:	Medical License #;
	Medicaid Provider #:
Richard H. Schultz, Administrator Division of Health Department of Health and Welfare	Date

(Continued)

MOU/PROVIDER ENROLLMENT AGREEMENT ADDITIONAL PROVIDERS WITHIN THE PRACTICE

Clinic/practice/agency:

List (**print or type**) each practitioner who will be administering vaccine in accordance with the MOU/Enrollment Agreement (signature of practitioner is **not** required). Please, list only those staff members with prescription writing privileges. People administering vaccines without prescription writing authority should not be listed.

Last Name	First	MI	Medical License No (Provider 1)	Title (MD, DO) must have prescripti	Specialty (Ped, GP, etc) ion writing privileges)	Medicaid Provider No
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